Commonwealth of Massachusetts
Health Care Quality and Cost Council
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Chair

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Executive Director

Health Care Quality and Cost Council

Meeting Minutes
Wednesday, January 2, 2008
1:00-3:00 p.m.
One Ashburton Place
21st Floor, Room 1
Boston, MA

Council Members Present: JudyAnn Bigby, Charlie Baker, Kevin Beagan, Elizabeth Capstick, James Conway, David Friedman, Kenneth LaBresh, Joseph Lawler, Thomas Lee, Katharine London, Dolores Mitchell, Robert Seifert, Gregory Sullivan.

Meeting called to order at 1:06pm

I. Approval Of Minutes of Council Meeting December 19, 2007

The Council approved the minutes of its December 19, 2007 meeting with amendments to the Executive Director's report regarding DHCFP involvement as the Council's Operations Vendor. Council agreed to change sentence under bullet 2 to state:

"The Council will work with Commissioner Sarah Iselin to see if the Division would be willing to serve as the Council's Operations Vendor subject to Council's approval."

The Council also agreed to amend language under Item for Discussion B (Budget update) to include the following language.

"The Council discussed the budget items listed and requested that the Governance Committee review the budget in detail and make recommendations on the spending plan for the remaining FY2008 funds."

II. Executive Director's Report

Katharine London announced that HCQCC is looking to hire an Executive Assistant. The position has been posted on the Mass.gov Human Resource website. Katharine encourages all interested parties to apply.

III. Items for Discussion

The Council agreed to rearrange the items on the agenda to include Don Berwick's presentation as the first item on the agenda.

A. Presentation from Don Berwick, resident and CEO of the Institute for Healthcare Improvement (IHI).

- Don Berwick discussed IHI's Triple Aim to improve individual patients' experience of care, improve the health of the population, and decrease the per-capita cost of care. He believes that it is possible to address all three goals at once, and that other countries have been successful in these efforts.

- Dr. Berwick believes 30% of the dollars spent on health care are wasted. However, our health care spending is an economic problem of the commons: any changes to the system to make improvements for everyone will financially hurt individual participants. He identified ten areas that the Council should focus on to reduce excessive costs.
    1. Transaction costs resulting from variations in procedures and reporting across payers
    2. Re-hospitalizations for chronic illness; 90% should be preventable
    3. Avoidable complications occurring in hospitals, e.g. injuries and infections
    4. Production without added value. Payers should de-couple payments from volume to encourage optimum service provision. Dr. Berwick challenged each medical specialty to identify 10 cost wasters.
    5. End of life care – people receive a lot of care at the end of their lives that they don't want, and this care is expensive
    6. Uncoordinated care. We need to strengthen primary care teams and nurse-based care to provide coordinated care, especially for chronically ill individuals.
    7. Poorly integrated care. In England, a patient's General Practitioner is responsible for integrating the patient's care, in Sweden it is the County Council. No one has that responsibility here. Patients should have a medical home. The Commonwealth Fund operationally defined a medical home as meeting these four conditions for patients: I have a doctor or nurse; I can reach that person during the day; that person knows my conditions; and that person knows if I see another clinician.
    8. Oversupply. Fisher and Wennberg showed that regions with lower cost per capita have better quality of care than regions with higher cost per capita. Excess supply leads to increased demand, and the highest levels of supply can lead to perceived shortages.
    9. Funding at the population level. There should be a budget for the population, and that budget should be allocated prudently.
    10. Engineering sciences. Managing patient flow, scheduling and resource allocation could vastly improve efficiency.

B. Update on Claims Data Submissions

Suanne Singer from the Maine Health Information Center reported updates on the claims data submission process. She reported that:

- Payers have been maintaining open communication lines and submitting test data

- Two health insurance carriers have been approved to submit historical data for eligibility and pharmacy claims: Cigna and Connecticut Life. She expects that more carriers will be approved for historical data submission in the next two weeks.
- During the first six weeks of the system, MHIC processed 28.7 million records in 246 file submissions.
- PBMs generally will only submit pharmacy claims data at the request of the insurance carriers. Nationwide has so far declined to require its PBM, XpresScripts to submit its pharmacy claims.

C. Approval of Web Development RFP.

- On December 19, 2007 the Council agreed to postpone its vote on the Web Development RFP so that members could have additional time to review the document. Between December 19 and January 2, Council staff received and incorporated feedback from IT personnel to make sure the document included all necessary specifications.

- Katharine London reviewed the scope of service and discussed the relationship between the Web Development vendor and the Council's other vendors.

- The Council approved the Web Development RFP with the following amendments.
  The Council agreed to remove the Division of Health Care Finance and Policy as the Data Operations Vendor as listed on the document and to add the term "for approval by the Council" to the summary of the Analytic Consulting vendor's scope of work.

  The Council also agreed to added to the Price Proposal a section for incremental prices associated with requirements that exceed the listed assumptions.

D. Recommendations from Ad Hoc Committee on Goal 1 Motion.

- JudyAnn Bigby summarized the Ad Hoc Committee meeting that took place on Friday, December 28, 2008. The Ad Hoc Committee met for two hours to review and discuss the recommendations for *Goal 1,* in accordance with a motion made during the December 19, 2007 Council meeting.

- Secretary Bigby stated that after deliberation and review the Ad Hoc Committee made amendments to language and format that best suited the Council's goals and direction moving forward. The Committee voted to recommend the revised document to the full Council.

- The Council discussed changes made to *Goal 1* and voted to adopt the document as amended. The final approved document is attached.

Meeting Adjourned at 3:02pm

Recommendations approved by the Council at its January 2, 2008 meeting

In accordance with the provisions of Sections 16K and 16L of Chapter 6A of the Massachusetts General Laws, the Council adopts the following Steps Needed to Achieve Council Goal I:

Strategy 1. The Council will contract with independent experts to provide the council with technical assistance in analyzing the causes of increases or decreases in health care costs, including but not limited to the effects of (1) supply of and demand for services, as well as utilization trends, (2) concentration of provider market power by geographic region and medical service, (3) concentration of insurer market power, (4) quality of care and avoidable medical errors, (5) avoidable administrative costs, (6) payment systems, (7) overuse and inappropriate use of medical technology, pharmaceuticals, and medical devices; on health care costs in the Commonwealth.

Strategy 2. The Council will adopt a standard of measurement of total annual Massachusetts health care spending (the "Massachusetts Global Health Cost Indicator") by which the Council will track the rate of increase or decrease in health care costs in total and within health care sectors from year to year. The Council will contract with an independent health care organization to provide the council with technical assistance in establishing and computing the Massachusetts Global Health Cost Indicator ("MGHCI"), in accordance with the provisions of Section 16L of Chapter 6A;

Strategy 3. The Council will develop legislative, regulatory, and other recommendations to control health care costs. The recommendations will be submitted by the Council to the appropriate entity in accordance with the provisions of Section 16L (m) of Chapter 6A. The Council will contract with independent experts to provide the Council with technical assistance in developing the recommendations. In developing the recommendations, the Council shall consider the following categories of options, among others:

a) rate regulation, such as rate setting for Massachusetts health care providers and health care insurers;
b) controlling the supply of services, such as expansion of the Commonwealth's Determination of Need program and/or strengthening its enforcement provisions;
c) redesigning the delivery system, such as instituting medical homes and expanding primary care, reducing avoidable hospitalizations, improving end of life care, and improving coordination of care;
d) payment reform, such as evaluating alternatives to fee-for-service systems, evaluating the impact of cost-sharing measures, including but not limited to circumstances where a patient has a choice of providers or products, and considering uses of reinsurance models;
e) identifying sources of funding for prevention and other cost containment initiatives, including the use of new assessments;
f) disseminating information relating to cost and clinical effectiveness, such as comparative effectiveness studies;
g) malpractice reform;
h) evaluating strategies for decreasing detrimental concentrations of market power in the provider and health insurer sectors;
i) evaluating employer and patient expectations;
j) administrative simplification;
k) assessing uses of medical technology, electronic health records, and computerized physician order entry; and
l) examining plan benefit designs.

The recommendations shall include an estimate of cost savings, as well as recommendations for implementation and tracking. The recommendations shall be prioritized by the Council, with assistance from the independent experts, by effectiveness, by ease of implementation, and by impact on access, quality of care, and disparities in provision of care. The recommendations shall also take into account impact on the viability of health care institutions and providers, especially those based in the community.

Strategy 4. The Council will prepare reports to be presented to the Governor, Secretary of Health and Human Services, Senate President, Speaker, and Chairpersons of the Committees on Ways and Means and Health Care Financing, comparing variations in rates paid by insured health plans, self-insured entities, Medicaid, Medicare, uninsured persons, and other payers to health care providers in the Commonwealth. The Council will ensure that the content and dissemination of any such report conforms to the relevant confidentiality laws and regulations.

Strategy 5. The Council will request adequate funding to support Steps 1 through 4.